



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

MMC OF EAST TEXAS

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-14-3200-01

**Carrier's Austin Representative Box**

Box Number 54

**MFDR Date Received**

JUNE 20, 2013

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We would contend that these denied charges qualify for an exemption under TEX. LAB. CODE §408.0272(b)(1)(A) inasmuch as the attached bill was mistakenly submitted to the incorrect workers compensation carrier during the 90 day window prescribed by 28 TEX. ADMIN. CODE §133.20(b)..."

**Amount in Dispute:** \$2,899.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "MMCET submitted its bill to the employer based on information provided by the employer... The rationale given by the requestor for the late bill is not consistent with the Rule above."

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2013	Hospital Outpatient Services	\$339.02	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by the health care provider.

**Issues**

1. Did the requestor bill the injured workers employer?
2. Is the requestor entitled to reimbursement?

## **Findings**

1. According to the requestor's position summary, they initially billed the injured workers employer. According to 28 Texas Labor Code §133.20(j), the health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following: (1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: (C) medical dispute resolution as provided by Labor Code §413.031.
2. The Division finds that the requestor has waived its right to Medical Fee Dispute Resolution pursuant to §133.20(j)(1)(C).

## **Conclusion**

For the reasons stated above, the Division finds that the reimbursement is not recommended. As a result, the amount ordered is \$0.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

## **Authorized Signature**

_____	_____	<u>November 21, 2014</u>
Signature	Medical Fee Dispute Resolution Officer	Date

## ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**